HEALTHPLEX CLINICAL CRITERIA FOR DENTAL SERVICES: ESSENTIAL SERVICES

Introduction

The Healthplex clinical criteria applies to the procedure codes, nomenclature and descriptors outlined in the most current version of the Current Dental Terminology (CDT) reference manual published by the American Dental Association.

Healthplex's Clinical Criteria for Dental Services are developed and maintained by the Healthplex Dental Director and are updated at least annually.

Criteria are created from an aggregate of information from:

- Current dental literature;
- Practice Parameters from the American Association of Periodontology (www.perio.org);
- Parameters of Care from the American Association of Oral and Maxillofacial Surgery (www.aaoms.org);
- Oral Health Policies and Clinical Guidelines from the American Academy of Pediatric Dentistry (www.aapd.org);
- Position Statements from the American Association of Dental Consultants (www.aadc.org);
- Dental Practice Parameters from the American Dental Association (www.ada.org);
- Evaluation of new and emerging technologies from participating dental professionals; and
- Public information from other insurance companies.

Criteria are reviewed and approved at least annually by Healthplex's Utilization Management Committee, whose clinical members include the Dental Director (a General Dentist), a member of the Healthplex Clinical Review Staff (typically a General Dentist or an Orthodontist), a practicing network general dentist, an Oral Surgeon, an Endodontist, a Periodontist, two Dental Hygienists and a Registered Nurse.

This document includes information pertaining to the most frequently billed services. Exceptions to published limitations are given on a case-by-case basis considering individual factors including but not limited to age, comorbidities, special needs and access to the local delivery system. This document is a supplement to be used in conjunction with the Dental

Policy and Procedure Code Manual published by New York State as well as the applicable contract between the enrollee and/or the Health Plan and Healthplex.

Dental Benefit Administration

Benefits for planned or rendered dental care are provided as defined in the members' contracts, which in addition to clinical criteria may include exclusions, limitations and administrative guidelines for certain procedures. Contracts vary depending on regulatory requirements and/or plan-specific rules and level of coverage.

The Professional Review Process

All Clinical Reviewers shall be licensed dental professionals with an appropriate level of education, training, and professional experience in clinical practice. Only a clinical peer reviewer, a licensed dentist, shall render an adverse determination if based on medical necessity rather than plan guidelines.

Clinical Reviewers shall evaluate requested services based on plan specific guidelines, clinical application of review criteria, patient condition, health history, and demographics (including but not limited to geographical area, assessment of the local delivery system, age, complications, progress of treatment, home environment and social habits). Based on an aggregate of these factors, the Reviewer shall indicate if the services are approved, denied, or if further information is needed to render a determination. Individual cases may be elevated to a Dental Director and/or their designated representative for consideration of special circumstances as necessary.

Scope of Coverage for Essential Services Programs

Programs like Medicaid provide coverage for essential dental services rather than comprehensive care.

Healthplex utilizes New York State's definition of essential services as described in the Dental Policy and Procedure Code Manual extracted from Version 2019 below:

"When reviewing requests for services the following guidelines will be used: Treatment will not be routinely approved when functional replacement with less costly restorative materials, including prosthetic replacement, is possible.

Caries index, periodontal status, recipient compliance, dental history, medical history and the overall status and prognosis of the entire dentition, among other factors, will be taken into consideration. Treatment is not considered appropriate when the prognosis of the tooth is questionable or when a reasonable alternative course of treatment would be extraction of the tooth and replacement. Treatment such as endodontics or crowns will not be approved in association with an existing or proposed prosthesis in the same arch, unless the tooth is a critical abutment for a prosthesis provided through the NYS Medicaid program, or unless replacement by addition to an existing prosthesis or new prosthesis is not feasible. If the total number of teeth which require, or are likely to require treatment would be considered excessive or when maintenance of the tooth is not considered

essential or appropriate in view of the overall dental status of the recipient, treatment will not be covered. Treatment of deciduous teeth when exfoliation is reasonably imminent will not be routinely reimbursable. Claims submitted for the treatment of deciduous cuspids and molars for children ten (10) years of age or older, or for deciduous incisors in children five (5) years of age or older will be pended for professional review. As a condition for payment, it may be necessary to submit, upon request, radiographic images and other information to support the appropriateness and necessity of these restorations. Extraction of deciduous teeth will only be reimbursed if injection of a local anesthetic is required.

Eight (8) posterior natural or prosthetic teeth (molars and/or bicuspids) in occlusion (four (4) maxillary and four (4) mandibular teeth in functional contact with each other) will be considered adequate for functional purposes. Requests will be reviewed for necessity based upon the presence/absence of eight (8) points of natural or prosthetic occlusal contact in the mouth (bicuspid/molar contact).

One (1) missing maxillary anterior tooth or two (2) missing mandibular anterior teeth may be considered an esthetic problem that warrants a prosthetic replacement."

In each procedure code category contained within the detail of this document, Healthplex explains how it specifically applies the principle of essential dentistry to each request for services.

Statement About Incentives

Healthplex, Inc. shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors based on:

1. A percentage of the amount by which a claim is reduced for payment or the number of claims or the cost of services for which the person has denied authorization or payment; or

2. Any other method that encourages the rendering of an adverse determination.

Healthplex, Inc. does not use incentives to encourage barriers to care and service. Decision-making is based solely on appropriateness of care and service combined with the applicable dental plan's scope of coverage. Healthplex, Inc. does not specifically reward any individual for issuing any denial of coverage or for encouraging decisions that result in underutilization.

COVERED PROCEDURES

A. DIAGNOSTIC SERVICES

Diagnostic Procedures Summary	Diagnostic services include an oral examination, caries risk assessment and select radiographs to assess the current status and to develop a treatment plan for the maintenance and/or restoration of a patient's oral health. Diagnostic procedures do not generally require prior approval or application of clinical criteria.
Comprehensive Evaluation	A comprehensive evaluation is a thorough examination and recording of the extraoral and intraoral hard and soft tissues. Documentation should include the patient's dental and medical history as well as medical consultation/clearance if indicated, evaluation and charting of dental caries, missing or unerupted teeth, restorations, prosthetic appliances, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies and any other pertinent information. This applies to new patients, established patients who have had a significant change in health conditions or other unusual circumstances such as established patients who have been absent from active treatment for three or more years. Reimbursement is limited to one exam (comprehensive or periodic) every 6 months and includes diagnosis, treatment planning and oral cancer screening.
Periodic Evaluation	A periodic evaluation is performed on a patient of record to determine any changes to dental and/or medical health status since the previous evaluation. Reibursement is limited to one exam (comprehensive or periodic) every 6 months and includes diagnosis, treatment planning and oral cancer screening.
Limited Evaluation – problem focused	A limited evaluation is performed when a patient presents with a specific problem, complaint and/or dental emergency. Please note: Follow-up visits related to previous treatment are not billable and therefore shall not be considered for separate reimbursement. Reimbursement is generally limited to once every three months (per issue) and is not separately payable if rendered on the same day as another exam or consultation.

Radiographs

To minimize a patient's radiation exposure, Healthplex recommends that providers exercise professional judgment and utilize the guidelines for prescribing dental radiographs published by the American Dental Association in collaboration with the U.S. Food & Drug Administration available online at: http://www.ada.org/~/media/ADA/Member%20Center/FIles/Dental_Radiographic_Examinations_2012.ashx.

A complete series (to be comprised of individual radiographs or a panoramic radiograph plus bitewings) is payable once every 36 months.

The maximum reimbursement for individual radiographs shall be limited to the fee for a complete series.

Panoramic radiographs are payable once every 36 months.

Cephalometric radiographs are payable once every 12 months to an orthodontist or oral surgeon for diagnostic purposes related to orthodontic treatment only.

Radiographs may be requested in order to obtain a determination for certain services. Please mount, date, and label **copies** of the most recent radiographs available. Originals should **always** be retained by the dentist.

Please note: Radiographs will be returned to your office upon request and ONLY if accompanied by a stamped, self-addressed envelope.

Diagnostic Casts

Diagnostic casts are payable to an orthodontist for diagnostic purposes related to orthodontic treatment only.

Diagnostic casts related to prosthetics are considered included in the allowance for the billable service.

B. PREVENTIVE SERVICES

Preventive Services Summary	Preventive services include routine prophylaxis, topical application of fluoride, sealants, oral hygiene instructions and space maintenance therapy. The goal of providing routine preventive dental services is to maintain oral health and to prevent the need for more extensive dental procedures. Preventive procedures do not require prior approval or application of clinical criteria.
Prophylaxis	Prophylaxis includes necessary scaling and polishing for the removal of plaque, calculus and stains from the tooth structures. Reimbursement is allowed once every 6 months. Beneficiaries with disabilities are eligible for prophylaxis as often as every three months
Fluoride	Topical application of fluoride is allowed once every 6 months up to age 20. Beneficiaries with disabilities (adults and children) are eligible for topical fluoride as often as every three months. For children under age 6 with a high caries risk, fluoride varnish can be applied up to 4 times in a 12 month period.
Sealants	Sealants should be applied to occlusal surfaces (and buccal/lingual pits and grooves when applicable) of previously unrestored and caries free erupted first and second permanent molars. Sealants shall be limited to once every 60 months for patients through age 15.
Space Maintainer	A space maintainer is covered when indicated due to the premature loss of a primary tooth. Removal of a fixed appliance is limited to once per lifetime to an office other than that of the original rendering provider. Lifetime reimbursement for a unilateral appliance is once per quadrant and for a bilateral appliance is once per arch.

C. RESTORATIVE SERVICES

Restorative Services Summary

Restorative services most commonly include amalgam and composite restorations, post and core, and crown. Amalgam and composite restorations as well as stainless steel crowns on primary teeth do not require prior approval or application of clinical criteria. Prior authorization is recommended for all other covered restorative procedures as clinical criteria apply.

Restorations placed solely for abrasion, attrition or for cosmetic purposes are beyond the scope of the program.

Repeated unexplained failure of any type of restoration will result in peer review and may necessitate removal of the dentist from the network and/or further disciplinary action.

Amalgam & Composite Restorations

Bases, cements, liners, pulp caps, bonding agents and local anesthetic are included in the restorative service fees and shall not be reimbursed separately.

Restorations are expected to last a reasonable amount of time but no less than 24 months.

Total restoration per tooth by amalgam and/or composite is not to exceed the allowable fee for a four surface restoration within 24 months.

If an amalgam or composite restoration is billed on the same day as a post and core, separate reimbursement shall not be available for the restoration.

Post and Core & Crowns

A request for a post and core and/or crown shall be automatically approved if the tooth has recent history of approved endodontic treatment. In the absence of recent endodontic treatment, the request requires clinical review of pre-operative radiographs and a full mouth treatment plan to substantiate medical necessity. Consideration for post and core is contingent upon the approval of the corresponding root canal and crown.

The determination of coverage will be based on the status of the individual tooth as well as the condition of the remaining teeth and supporting tissue. Factors considered include but are not limited to: medical necessity, periodontal condition, restorative prognosis, endodontic prognosis, missing teeth, integrity of the opposing dentition, and existing or proposed prosthesis in the same or opposing arch.

For a patient age 21 and over, a crown will not be routinely approved in association with an existing or proposed prosthesis in the same arch unless the tooth is a critical abutment or if functional replacement with less costly materials, including prosthetic replacement is possible.

Payment for a post and core and/or crown includes any adjustments or re-cementation necessary during the six month period following its initial placement.

Replacement of an existing crown will be reviewed for medical necessity considering preoperative radiographs, date of prior placement, replacement reason, and special circumstances if applicable.

Reimbursement for a post and core and/or crown is available once every 60 months.

D. ENDODONTIC SERVICES

Endodontic Services Summary

Endodontic services most commonly include pulpotomy, root canal therapy, retreatment of previous root canal therapy, and apicoectomy. Clinical criteria apply to all covered endodontic procedures with exception of pulpotomy, therefore prior authorization for these services is recommended. Noted patterns of endodontic treatment failure will result in peer review and may necessitate removal of the dentist from the network and/or further disciplinary action.

When endodontic therapy is indicated in an urgent situation, it is expected that appropriate palliative measures shall be initiated. Please contact Healthplex with any questions related to coverage and/or to request an expedited prior authorization.

If endodontic therapy is rendered in the absence of a prior authorization, please submit your claim with recent pre-operative and post-operative radiographs for retrospective review.

Pulpotomy

The aim of pulpotomy is to maintain the vitality of the remaining portion by means of an adequate dressing. It is not to be construed as the first stage of root canal therapy. Therefore if root canal is performed by the same provider, any allowance paid shall be deducted from the fee for root canal therapy.

Reimbursement for a pulpotomy is available once per tooth and is available up to age 21.

Pulpal Therapy

Pulpal therapy shall include pulpectomy, cleaning, and filling of canals with resorbable material.

A post-operative radiograph is requested upon completion. If canals are not sufficiently filled to the apex, benefit for pulpotomy will be allowed.

Reimbursement for a pulpal therapy is available once per tooth

Root Canal Therapy

Root canal therapy shall include pulpal extirpation, endodontic treatment to include complete filling of the canal(s) with permanent material, all necessary radiographs during treatment, a radiograph demonstrating proper completion, and follow-up care.

The acceptable standard employed for endodontic procedures dictates that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet acceptable standards, Healthplex reserves the right to require that the procedure be redone at no additional cost. Refund may be requested for any reimbursement made for an inadequate service.

Requests for endodontic therapy or retreatment require clinical review of pre-operative radiographs and a full mouth treatment plan. The determination of coverage will be based on the status of the individual tooth as well as the condition of the remaining teeth and supporting tissue. Factors considered include but are not limited to:

- Medical necessity
- Periodontal condition
- Restorative prognosis
- Missing teeth
- Presence of root resorption
- Integrity of the opposing dentition
- Existing or proposed prosthesis in the same or opposing arch

For a patient age 21 and over, endodontic therapy will not be routinely approved in association with an existing or proposed prosthesis in the same arch unless the tooth is a critical abutment or if functional replacement with less costly materials, including prosthetic replacement is possible.

For a patient age 21 and over, molar endodontic therapy will be considered only in those instances where the tooth in question is a critical abutment for an existing functional prosthesis and when the tooth cannot be extracted and replaced with a new prosthesis.

Reimbursement for root canal therapy and/or retreatment is once per tooth.

Apicoectomy

Apicoectomy will be considered only if one or more of the following conditions exist:

- Overfilled canal (previously treated tooth) or displaced root canal filling irritating periapical tissues
- Canal cannot be filled properly due to excessive root curvature or calcification, fractured root tip, broken instrument in canal, or perforation of the apical third of canal
- Periapical pathology not resolved by previous endodontic therapy
- A post which cannot be removed.

Please refer to clinical criteria for endodontic therapy listed in the root canal section above.

Reimbursement for root canal therapy and/or retreatment is once per tooth

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Apexification	Requests for reimbursement for apexification require clinical review of pre-operative radiographs to substantiate medical necessity. Factors such as restorative prognosis and presence of open apices are considered for determination of coverage. Reimbursement for apexification is once per tooth.

E. PERIODONTIC SERVICES

Periodontic Services Summary

The most common periodontic services are periodontal scaling & root planing and gingivectomy/gingivoplasty. Clinical criteria apply to all covered periodontic procedures, therefore prior authorization for these services is recommended.

Periodontal surgery (except for gingivectomy/gingivoplasty) is not within the scope of services covered by the program.

When periodontal services are indicated, the provider must keep on file documentation of the need for treatment, including a copy of the pre-treatment evaluation of the periodontium, a general description of the tissues (i.e. color, shape, and consistency), the location and measurement of periodontal pockets, the description of the type and amount of bone loss, the periodontal diagnosis, the amount and location of subgingival calculus deposits, and tooth mobility.

Periodontal scaling & root planing

Periodontal scaling & root planing is indicated for patients with moderate to severe periodontal disease and is therapeutic not prophylactic in nature. It involves instrumentation of the crown and root surfaces to remove plaque and calculus.

Current periodontal charting in conjunction with appropriate radiographs should be submitted for review. Factors such as pocket depth and bone loss shall be considered. For approval of the requested quadrant, there must be a minimum of one pocket of at least 5mm or one pocket of at least 4mm with evidence of bone loss of more than 2mm from the CEJ (cemento/enamel junction).

If less than 4 teeth are present in the quadrant, a partial quadrant will allowed.

Please note that your periodontal charting must be an accurate representation of the patient's current condition. Noted patterns of inconsistency between periodontal charting and radiographs and/or dental history will result in peer review and may necessitate removal of the dentist from the network and/or further disciplinary action.

Reimbursement for each quadrant is available once every 24 months.

Periodontal Surgery

Covered periodontal surgery includes gingivectomy/gingivoplasty only. This service is reimbursable solely for the correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects.

Current periodontal charting and/or photos in conjunction with appropriate radiographs and a narrative substantiating the causative factor(s) should be submitted for clinical review for prior authorization.

If less than 4 teeth are present in the quadrant, a partial quadrant will allowed.

Reimbursement for each quadrant is available once every 12 months.

F. PROSTHETIC SERVICES

Prosthetic Services Summary

Prosthetic services most commonly include removable dentures. Clinical criteria apply to all covered prosthetics without regard to material, therefore prior authorization for these services is recommended. Full and/or partial dentures are covered when they are required to alleviate a serious health condition or one that affects employability.

Fixed partial dentures are not generally considered within the scope of services covered by the program. If extenuating circumstances exist, please submit a prior authorization request with a narrative for consideration.

Implants shall be considered when medically necessary and shall only be considered if other covered functional alternatives for prosthetic replacement will not correct the patient's dental condition.

In situations where it is impractical to obtain pre-operative radiographs on a patient in a nursing home or long term care facility, a written narrative by the dentist stating that the patient is in a physical and mental state sufficient to function with dentures is required for authorization.

Claims are not to be submitted until the denture(s) are completed and delivered to the member.

Removable Prosthetic Services

Dentures, both partial and complete, shall be considered when masticatory function is likely to impair the general health of the patient or when the existing prosthesis is at least 8 years old and unserviceable or if recent extensive physiological change (i.e. recent extraction of 4 or more teeth, marked weight loss, trauma, etc.) has occurred. Exceptions based on medical necessity for individual factors shall be considered on a case by case basis.

Requests for replacement dentures whether unserviceable, lost, stolen, or broken prior to 8 years must include a letter from the patient's physician and dentist which explains the specific circumstances that necessitate replacement of the denture. The letter must clearly indicate how the denture(s) will alleviate the patient's serious health condition or improve employability. If replacement dentures are requested within the 8 year period after they have already been replaced once, the supporting documentation must include an explanation of preventative measures instituted to alleviate the need for further replacements.

For requests for a complete denture:

- If initial placement for a non-edentulous arch, a full mouth treatment plan and preoperative radiographs are required to substantiate medical necessity.

- If initial placement for an edentulous arch, the request shall be automatically approved.
- For replacement of an existing complete denture, prior insertion date and reason for replacement are needed for a determination of coverage.

For requests for a partial denture:

- If initial placement, a full mouth treatment plan and preoperative radiographs are required to substantiate medical necessity.
- For replacement of an existing partial denture, a full mouth treatment plan, preoperative radiographs, prior insertion date and reason for replacement are needed for a determination of coverage.
- Please note that all necessary restorative work must be completed before fabrication of a partial denture.

The determination of coverage will be based on:

- Radiographic evaluation of current status of the dentition as well as appropriateness of the proposed treatment plan (i.e. planned extractions, prognosis of remaining teeth, etc.).
- Partial dentures will be allowed if there is at least one missing maxillary anterior tooth or two missing mandibular teeth or if there are less than eight natural or prosthetic posterior teeth in occlusion (four maxillary and four mandibular teeth in functional contact with each other).
- Abutments for a partial denture must be free of active periodontal disease and have adequate bone support.
- Individual psychosocial factors shall be considered on a case by case basis.

Immediate prosthetic appliances are not a covered service. It is expected that tissues will be allowed to heal for a minimum for 4-6 weeks prior to taking the final impression(s).

Partial dentures can be considered for patients age 15 and above. An interim prosthesis (codes D5820/D5821) can be considered for patients between ages 5 to 15.

An implant supported prosthetic shall be considered using the medical necessity criteria related to the implants. Please refer to the Implant section below.

Reimbursement for a denture is available once every 96 months. Consideration of replacement outside of this expectation shall be based on documented medical necessity and individual circumstances.

Denture Repairs, Relines, and Adjustments

Payment for a new prosthesis includes any adjustments necessary during the 6 month period following delivery.

If the reimbursement for any combination of repairs, relines, and/or adjustments shall exceed 50% of the cost of a new denture, please submit a prior authorization request for consideration of a new denture.

Reimbursement for all repairs, chairside relines and adjustments are available once every 12 months. Reimbursement for lab relines are available once every 24 months, and rebases once every 48 months.

Implant Services

Dental implants will be covered by Medicaid when **medically necessary and only when other covered functional alternatives for prosthetic replacement will not correct the patient's dental condition.** Prior approval requests for implants must include:

- Accurate pretreatment charting;
- Complete treatment plan addressing all areas of pathology;
- Interarch distance;
- Number, type and location of implants to be placed;
- Design and type of planned restoration(s)/prosthetic(s);
- A letter from the patient's physician must explain how implants will alleviate the patient's medical condition;
- A letter from the patient's dentist must explain why other covered functional alternatives for prosthetic replacement will not correct the patient's dental condition and why the patient requires implants; and
- Current, diagnostic x-rays allowing evaluation of the entire dentition.

In the event that an implant is approved, other necessary services required for the dental implant surgery like bone grafting will considered on a case by case basis.

If bone grafting is necessary, there must be a 4-6 month healing period before the implant can be placed.

The request for the implant (code D6010) will be re-evaluated 4-6 months after placement via x-rays or CT scan **prior to** authorization of abutment(s), crown(s), or denture(s).

Treatment on an existing implant will be evaluated on a case by case basis.

G. ORAL AND MAXILLOFACIAL SURGICAL SERVICES

Oral Surgical Services Summary

Oral Surgery procedures most commonly include extractions, alveoloplasty, and biopsies.

Reimbursement requests for all oral surgery procedures with exception of non-surgical extractions require clinical review of applicable diagnostics (i.e. pre-operative radiographs, biopsy report, and/or narrative) to substantiate medical necessity.

Oral surgical services (i.e. extractions or exposures) for orthodontic purposes are covered only if the corresponding orthodontic treatment has been approved by Healthplex.

Extractions

Removal of tooth, soft tissue associated with the root, curettage of the socket, local anesthesia, required suturing, and routine post-operative care are included in the fees for extractions and will not be reimbursed separately. Excision of tissue, particularly cyst removal, requires supporting documentation when billed as an adjunct to tooth extraction.

Extraction of impacted teeth should only be undertaken when conditions arising from such impactions warrant their removal. The extraction of asymptomatic teeth or those teeth where medical/dental necessity cannot be demonstrated shall be disallowed.

Coverage is based on medical necessity and the anatomical position of the tooth.

Excision and Biopsy

Excision of tissue, particularly cyst removal, requires supporting documentation when billed as an adjunct to tooth extraction. Removal or biopsy of a periapical granuloma, dentigerous or odontogenic cyst is generally considered an integral part of the extraction and is not separately billable.

Excision and biopsy submitted on the same day is considered a duplicate service. Benefit only for the excision shall be considered.

Incision and Drainage

Incision and drainage procedures include the insertion and removal of drain(s). When submitted on the same day as another definitive service in the same quadrant, supporting documentation (i.e. radiographs or treatment record) is required for consideration for separate reimbursement.

Alveoloplasty	When submitted in conjunction with surgical extractions in the same quadrant, alveoloplasty is considered included in the allowance for the surgical service and not reimbursable as a separate procedure. If submitted without extractions in the same quadrant, please submit a narrative substantiating medical necessity. If alveoloplasty is performed for less than 4 teeth or tooth spaces in the quadrant, a partial quadrant will allowed.
Other Surgical Services	For all other covered oral surgical services, please submit pre-operative radiographs with a narrative substantiating medical necessity for consideration.

H. ORTHODONTIC SERVICES

Orthodontic Services Summary

Limited, Interceptive and Comprehensive orthodontic services must be prior authorized. Limited or Interceptive orthodontic services will be considered for the treatment of the primary or transitional dentition. Limited or Comprehensive orthodontic services will be considered for treatment of the transitional, adolescent or permanent dentition.

For comprehensive orthodontic treatment, if the total score on the HLD Assessment Tool is equal to or greater than 26, the pre-orthodontic treatment work-up can proceed. If the total score on the HLD Assessment Tool is less than 26 points, please submit documentation of the extenuating functional difficulties and/or medical anomaly with the submission.

The pre-orthodontic treatment visit does not require prior authorization. Reimbursement is available once per 12 months prior to initiation of orthodontic treatment and includes the consultation; therefore, consultation will not be reimbursed separately.

Limited Orthodontic Treatment

Limited orthodontic treatment can be considered for treatment with a limited objective, not involving the entire dentition. It may be directed at the only existing problem or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy.

For prior authorization the following shall be submitted:

- Narrative of clinical findings and treatment plan;
- Diagnostic photographs;
- Diagnostic radiographs of the entire dentition;

Reimbursement is limited to once per lifetime for an approved course of orthodontic treatment.

Interceptive Orthodontic Treatment

Consideration is given when interceptive orthodontic treatment may eliminate the need for or reduce the severity or duration of comprehensive orthodontic treatment. Approval for the interceptive treatment when not part of the comprehensive case will include all appliances, insertion, treatment visits, repairs, removal and retention. As a result, the provider shall complete the case even if eligibility is terminated.

For prior authorization requests the following shall be submitted:

- Narrative of clinical findings for dysfunction or deformity and dental diagnosis;
- Orthodontic treatment plan to include description of appliance(s);
- Diagnostic photographs;

- Diagnostic panoramic radiographs and cephalometric films with tracing (when applicable); and,

If comprehensive treatment is required following a course of interceptive treatment, a period of 12 to 18 months should be allowed prior to requesting comprehensive treatment for stabilization of the result.

Reimbursement is limited to once per lifetime for an approved course of orthodontic treatment.

Comprehensive Orthodontic Treatment

Comprehensive orthodontic treatment will only be considered for the adolescent or permanent dentition.

For prior authorization requests the following shall be submitted:

- The completed HLD Assessment Tool;
- Narrative of clinical findings for dysfunction or deformity and dental diagnosis;
- The comprehensive orthodontic treatment plan;
- Diagnostic cast or digital study models;
- Diagnostic photographs;
- Diagnostic panoramic radiographs and cephalometric films with tracing (when applicable);
- For orthognathic surgical cases: the surgical consult, complete treatment plan and approval for surgical treatment with a statement signed by the parent/guardian and recipient that they understand and accept the proposed treatment is necessary; and,
- Medical diagnosis (when applicable).

Please note: All needed dental treatment (preventive and restorative) should be completed prior to initiating orthodontic treatment.

In addition to submission requirements already noted, the following must be met:

- The prior authorization request to start a case must include treatment visits. Treatment visits will be considered for 4 quarterly intervals. The maximum number of treatment visits to be considered on any one prior authorization is 4;
- After the initial 4 quarterly treatment visits, recertification for the remainder of the treatment is necessary. Please submit current progress photographs with a copy of the treatment record for review.
- The case start date is considered to be the banding date which must occur within six (6) months of approval;
- The case fee includes active and retention phase of treatment and is based on eligibility and age limitations.

Prior Authorization for Orthodontic Services Transferred or Started Outside of the Program

For continuation of care for transfer cases, a prior authorization must be submitted to request the remaining treatment visits for case completion. The following must be submitted with the prior authorization:

- A copy of the initial orthodontic case approval if applicable;
- A copy of the orthodontic treatment notes if available from provider that started the case;
- Recent diagnostic photographs; and,
- The date when active treatment was started and the expected number of months for active treatment.

Documentation for Completion of Comprehensive Cases – Final Records

Attestation of case completion must be submitted on the provider's letterhead to document that active treatment had a favorable outcome and that the case is ready for retention. Procedure code D8680, orthodontic retention shall be submitted on the visit to remove the bands and place the case in retention.

I. ADJUNCTIVE GENERAL SERVICES

Adjunctive General Services Summary

Adjunctive general services most commonly include general anesthesia, intravenous sedation, consultations and palliative services provided for relief of dental pain.

Palliative Treatment

Reimbursement is per visit and is generally limited to once every 3 months (per issue) and is not separately payable if rendered on the same day as another payable procedure other than diagnostic services.

Please include tooth number or area and a description of the procedure rendered.

Please note: Follow-up visits related to previous treatment are not billable and therefore shall not be considered for separate reimbursement.

Intravenous Conscious Sedation and General Anesthesia

Intravenous conscious sedation and general anesthesia are payable only if the provider holds a current certification and licensure to administer such anesthesia per state and federal guidelines.

For cases requiring intravenous sedation or general anesthesia, providers must retain the anesthesia record which documents time and amounts of drugs administered, pulse rate, blood pressure, respiration, etc. in the patient's treatment record.

Healthplex recommends that providers exercise professional judgment when diagnosing the necessity for administration of intravenous sedation or general anesthesia. Apprehension alone is not typically considered a medical necessity.

Consultation (D9310)

A consultation includes an oral evaluation and will only be reimbursed to a specialist.

Reimbursement for a consultation is generally limited to once per 3 months (per treatment plan).